

Informed Opinion

A Clinician Looks at Health Planning

RALPH CRAWSHAW, MD, *Portland*

The purpose of this paper is to encourage physicians to use their clinical thinking in a leadership role—advising, interpreting and innovating—in the presently evolving health planning. As with the successful practice of medicine, where clinical thinking involves translating the medical needs of the patient into a language the patient understands rather than simply prescribing a course of therapy, so successful health planning needs careful and detailed interpretation by the physician to the public rather than a prescribed course of action concerning particular institutions or public policy. Now that federal health planning is being decentralized, there is a unique opportunity for physicians to replace previous politically polarized attitudes with a powerful means for constructive change, clinical thinking, the dispassionate judgment of what is best for the patient, based on medical knowledge and experience.

Future Trends

Though national health planning disappoints most concerned observers, significant improvement is possible. There is the strong possibility that we are entering a “self-service society,” where local volunteers will enhance and develop a new type of functional health planning system as an extension of grass roots politics. Many more concerned and informed consumers can be expected to enter and sustain health planning, now in their own way, perhaps even making it a potent community instrument. Nathan Glazer has noted, “Between 1965 and 1971, according to the Department of Labor, the number of Americans doing volunteer work increased from 22,000,000 to 37,000,000, a trend which appears to be accelerating.”^{1(p88)}

A second driving force for change is the inexorable pressure of technological innovation, which delivers ever-increasing specialized intense medical service to fewer and fewer people, apparently at the expense of the poor and the disenfranchised, preventing, and lately even jeopardizing, general hospital services. (At present, coronary artery bypass surgery, serving 0.04% of the nation's population, accounts for 1% of the nation's health bills. The end-stage renal disease program, serving less than 0.25% of all medicare part B

beneficiaries, accounts for more than 9% of medicare expenditure.²⁾ The present failure of health planning to articulate the broad implications of health care allocation can be expected to change as explicit medical care rationing is forced upon the nation. The balance between curative medicine and prevention and between low tech medicine and high tech medicine demands a rational forum in which neither is neglected and both are encouraged, despite the state of financial triage. The need for clinical thinking increases as health planning, willy-nilly, is forced to cope with these vast problems.

Past Trends

The following example should clarify a chronic pitfall physicians have fallen into when failing to apply clinical thinking to the body politic. While proposing legislation altering the configuration of state health planning to more closely reflect present needs, Oregon's chief state health planning administrator was invited by the state medical association's Subcommittee on Public Policy for a dinner meeting of “informal” talk. Since he wished to secure input from the physicians, as well as share the reason for proposed changes, he agreed, but he found himself alone with six doctors and two hospital administrators who spent the evening lecturing him on “the demeaning, insinuating and inflammatory language” of the proposed bill. This was done after the medical association had already established its policy, strongly disapproving the legislation. The next morning the chairman of the subcommittee apologized by telephone for what had happened, but by then the damage was done. It is unlikely that any member of that subcommittee in practicing medicine would lecture patients about “demeaning, insinuating and inflammatory language” as part of a therapeutic program; yet, when treating the body politic, one and all abandoned their sound clinical thinking. Certainly, none extended their clinical philosophy in keeping with the American Medical Association's policy that calls for voluntary health planning as a collaborative community effort to develop and use health resources in an orderly fashion.

(Crawshaw R: A clinician looks at health planning [Informed Opinion]. West J Med 1984 Oct; 141:531-533)

Dr Crawshaw is Chairman of the Oregon Statewide Health Coordinating Council and in private practice in Portland.
Reprint requests to Ralph Crawshaw, MD, 2525 NW Lovejoy St, Suite 404, Portland, OR 97210.

ABBREVIATIONS USED IN TEXT

SHCC=Statewide Health Coordinating Council
 SHPDA=State Health Planning Development Agency

The Process

The extension of clinical thinking to health planning is not so complex that most physicians cannot intuitively appreciate it. First, a diagnosis is established. Then, a consideration of alternative therapeutic approaches, which carefully evaluates the patient's resources, is undertaken and shared with the patient in an understandable fashion, followed by an ongoing, collaborative effort to correct the pathologic condition.

Much of the present difficulty in treating the body politic does not arise out of the diagnosis, but from the new and complex languages which seriously interfere with the physicians' communication and collaboration in considering therapeutic alternatives. For example, in the past when a community needed a new service—a burn center, for example—it was relatively easy for the physicians to make the case in a language that was understandable to most thinking citizens, and after a period of deliberation and fund raising, the medical resource would be established. Now, because of the involved nature of medical care, cost increases, burgeoning technology and an aging and more demanding public, now called “consumers,” physicians are faced with a confusing situation in which there are a number of “new” experts with their own language. Despite this proliferation of tongues and complexity of fulfillment, physicians' most powerful tool for constructive change remains, clinically thinking, “What is best for the patient?”

The Oregon Statewide Health Coordinating Council (SHCC—pronounced “shick”) serves as an example of the unavoidable complexity that accompanies clinical thinking in a public arena. Like presently evolving boards of hospitals, medical licensure, professional standards review organizations, business and labor health coalitions and boards of health, the SHCC has consumer representation; in fact, a majority are consumers. No longer is it possible for a physician to simply lay out the “diagnosis” for health planning to the 30 members of SHCC and expect direct implementation of the medical profession's treatment plan. Nor is it enough for the physician to simply sit back and criticize or ridicule the plans of others. Clinical thinking must now be translated into citizens' language in open, sometimes contentious, “town hall” meetings.

The Languages

The consequent forum created within SHCC has three prime cohorts: planners, consumers and providers—each with interests arising from different areas, with different mind sets and, consequently, with different languages. Planners from the State Health Planning and Development Agency (SHPDA) are trained in the arcane language of political science, government

regulation and statistics. They are paid by the government to monitor and control the health delivery systems through academic principles of rational allocation of health resources. They speak “bureaucratese.” The providers, though a polyglot crowd, are dominated by physicians who are trained in an even more arcane language of scientific medicine, “medicalese.” The providers are seen as intent on following health planning along idiosyncratic practice styles which are frequently labeled as favoring their income and political self-interest. The third group, the consumers, the most heterogeneous, are not paid for their involvement in health care planning. In fact, consumers are frequently preoccupied with how much everyone else is being paid in the mounting cost of the entire enterprise. Consumers speak a language of personal experience with health care delivery, “pain and suffering,” which they hope proves useful by encouraging relevant community action.

Of the three languages, “pain and suffering,” the most difficult to articulate, is easily the most dramatically powerful. Should a President suffer from poliomyelitis, or have a close relative who is mentally retarded, forthwith the nation will have a formidable federal program to alleviate or eliminate that particular condition. Any doubts about Congress supporting end-stage renal dialysis were resolved in 1971 when the vice president of the National Association of Patients on Hemodialysis was dialyzed before the House Ways and Means Committee, blatant “pain and suffering” talk where it counts.

Patently, SHCC consumer members lack the political “eloquence” to articulate their pain and suffering as clearly as Presidents do. They are generally diffident and are more likely to speak “pain and suffering” in the bytalk of the SHCC meetings, during coffee breaks, confiding their concern about a husband committed to a state hospital, a child dying of leukemia, the neglect a fellow member of a minority has suffered, the need for an ambulance service in their rural area or all too often their outrage at mounting personal health insurance bills. They concur on the ultimate goal of health planning—equitable allocation of resources—but too often SHCC consumer members lack the means of translating their “pain and suffering” into the technical jargon of statistics and regulations. Understandably, the failure to translate their concepts of health planning into action leads to considerable frustration, as well as enforced dependence on health providers to speak for them. Their frustration was eloquently voiced when a consumer member of SHCC said, “I joined this outfit a number of years ago to find out what is really going on in health care, and we are still chasing government regulations. It is time we turned over a few rocks and see what crawls out.”

The Clinical Dynamic

The impact of these three languages on SHCC has been a three-way dynamic fluctuating from shrill power confrontations to harmonious negotiations. The dy-

namic had been anticipated by the framers of the original federal legislation who, suspicious that the providers would dominate planning, mandated a consumer majority for SHCC. The government's suspicion of providers is matched by the providers' unrelieved mistrust of the government. Its regulations are seen as intentionally stacked against providers, pitting them against consumers, in order to give the government a free hand for its own plans. Not surprisingly, any proposal originating with the planning establishment, the SHPDA, has been reflexly greeted with provider cries of "Pure ignorance of the real situation!"

Predictably, consumers initially felt outclassed in the babel of two unfamiliar languages, and sometimes voted with their feet. However, with diligence and careful attention, consumers have come to understand the power of their own language, "pain and suffering," particularly when courted for votes by one or another of the other two factions.

The fact that each cohort has its own mind set and language should not be construed to mean that coherence and agreement exist within cohorts, no more than it should be expected that all who speak English will agree. Planners at the SHPDA level have been at sharp odds with Health Service Agency planners about Certificate of Need decisions, consumers interested in antifluoridation have not hidden their displeasure with parent groups pressing for school administration of fluorides, and among the providers the dissension between the fee-for-service and health maintenance organization physicians has at times almost disrupted SHCC meetings. Such disagreements within cohorts are natural and expected, and though generating hard feelings and grudges, the internal dissensions have not destroyed the original commonality of purpose. The flaw of health planning occurs in the continuing, vast discord among three cohorts, each with its individual language, and the difficulty in developing the harmony necessary for relevant community action.

Results

As deep changes continue to shake existing planning institutions, the polyglot language of health planning should shift from national "bureaucratese" towards local "pain and suffering." It is then that "medicalese" based on extended clinical thinking has a unique potential for framing questions and translating ideas into the commonly understood language of constructive action. The recent economic recession presented the SHCC with such an opportunity. With unemployment rates high, approximately 300,000 Oregonians were without health insurance coverage. SHCC took a long hard look at a real and present problem not covered by federal regulations. Each cohort had its say and the consensus came with a decision to establish an indepen-

dent, Internal Revenue Service-approved foundation to take the problem of the "new poor" to the people through a conference financed by local money. The conference was fashioned from the grass roots up, with thoughtful input of all parties: consumers (some of whom were poor); providers; state, county and city government officials; business and labor representatives; ethicists; third party payors, and administrators. They met as vested, interested panels, each charged with producing their considered view of problems and solutions of health care for the medically poor of the state. After study and consensus with the panels, they convened in a conference, following regular rules of debate, and produced a health policy statement for Oregon's care of the medically poor. Direct results included a coalition of consumers and providers for increased health funding for the "new poor" through Title XIX funds, a call for a conference on bioethical issues, a series of epidemiological studies to accurately define the size of the problem of the "new poor" and increased public awareness of health care delivery problems. The consequent solidarity of purpose was voiced by the immediate past president of the Oregon Medical Association while testifying for the medically poor before the state legislature's Human Resources Committee: "This is the first time I have testified before a legislative committee and not been afraid to turn my back to the audience." A legislator on the committee replied, "Doctor, this is the first time I have been on your side." This is how it should be done for it resulted in a budget-cutting legislature appropriating 10 million dollars for the medically poor.

Conclusions

Physicians are wise to see health planning as a permanent part of health care delivery and, though now in a major transition, it may well emerge as an even more powerful community instrument. In order to focus health planning on prudent service to the sick, physicians must extend their clinical thinking to a new order of complexity which will successfully articulate community medical needs to government, business, labor and citizens in general. The new role demands an ability to understand and talk the "languages" of all those involved in health policy, facilitating full, open discussion that will lead to wisely informed, political consent by the public. The ultimate reward for physicians comes as our professional autonomy is enhanced by a public grateful for recognized service in achieving an enlightened and expanded community consensus.

REFERENCES

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